



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 5353.4A
BUMED-32CP
23 Nov 1999

BUMED INSTRUCTION 5353.4A

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: STANDARDS FOR PROVISION OF SUBSTANCE RELATED DISORDER
TREATMENT SERVICES

Ref: (a) Memorandum of Understanding between the Chief of
Naval Operations and Chief, Bureau of Medicine
and Surgery of 30 Jun 95 (NOTAL)
(b) DoD 1010.6 of 13 Mar 85 (NOTAL)
(c) OPNAVINST 5350.4C
(d) *Diagnostic and Statistical Manual of Mental
Disorders, Fourth Edition (DSM-IV)*
(e) American Society of Addiction Medicine, *Patient
Placement Criteria for the Treatment of Substance
Related Disorders* (PPC-2) (NOTAL)
(f) Joint Commission on Accreditation of Healthcare
Organizations Comprehensive Standards (JCAHO)
(g) BUMEDINST 6320.66B
(h) Manual of the Medical Department, NAVMED-P117

Encl: (1) DoD Policy Memorandum on TRICARE Substance Abuse
Treatment, HA Policy 97-029 of Feb 13, 1997
(2) Treatment Guidelines
(3) Levels of Care
(4) Patient Placement Dimensions and Adult Criteria:
Crosswalk of Levels of Service
(5) Clinical Institute Withdrawal Assessment of Alcohol
Scale
(6) Definitions

1. Purpose. To establish a uniform set of standards for the
provision of substance related disorder treatment services within
the Department of the Navy (DON). This is a complete revision
and must be read in its entirety.

2. Cancellation. BUMEDINST 5353.4.

3. Background. The memorandum of understanding (MOU) in
reference (a) established the Chief, Bureau of Medicine and
Surgery (BUMED) as responsible for management of the Navy

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Department program for substance related disorder treatment services, including management of the Navy Drug and Alcohol Counselor School and the Navy Preceptorship Program for drug and alcohol counselors. As a result of the MOU, funding responsibility for Navy substance related disorder treatment services is the responsibility of the Defense Health Program, except for the drug screening laboratories, Navy Preceptorship Program, and Navy Drug and Alcohol Counselor School, which remain the funding responsibility of the Navy line (Operation and Maintenance, Navy).

4. Policy. This instruction implements policies outlined in enclosure (1) for the delivery of a comprehensive TRICARE substance related disorder treatment benefit within the Navy direct health care system and aboard operational units. Enclosures (2) through (5) represent the scope of assessment and treatment services. Enclosure (6) defines terminology used in this instruction. Reference (b) provides information for implementing treatment services. Since assessment and treatment for substance use problems and substance related disorders impacts readiness, reference (c) contains administrative guidelines for active duty members. Diagnosis of substance abuse related disorders should follow reference (d). Reference (e) provides guidance for determining the intensity and duration of intervention. All treatment programs and services based in medical treatment facilities shall meet the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), reference (f). A licensed and privileged health care practitioner, as outlined in reference (g), will be responsible for all services provided by the substance abuse program. Health care records for substance abuse treatment will be maintained per reference (h). For administrative standardization, these services will be referred to as the Navy Substance Abuse Intervention and Treatment Program. The Assistant Chief for Health Care Operations, BUMED (MED-03), is the program manager.

5. Applicability

a. Commanding officers of naval medical treatment facilities (MTF) providing assessment and treatment services for substance related disorders shall:

(1) Work in close coordination with the regional lead agent, as designated by the Assistant Secretary of Defense (Health Affairs), to develop an integrated plan for the delivery of substance abuse services to beneficiaries.

(2) Ensure assessment and treatment services meet the guidance in this instruction.

(3) Submit required patient census data to BUMED (MED-32) to assist in system resource allocation and program outcomes measurement.

b. Commanding Officer, Naval School of Health Sciences (NSHS), San Diego, CA shall:

(1) Be responsible for the Navy Drug and Alcohol Counselor School (NDACS) which, through an intense, introductory training curriculum, prepares active duty personnel for a tour as a counselor intern within the Navy's Substance Abuse Treatment Program.

(2) Include BUMED (MED-03) in the development of the training requirements review inventory (TRI) for NDACS curriculum.

(3) Manage contracts aimed at counselor training and development, in consultation with the Assistant Chief for Health Care Operations, BUMED (MED-03) and the Assistant Chief for Education, Training and Personnel, BUMED (MED-05).

(4) Administer the substance abuse counselor certification program.

c. Operational medical units providing assessment and treatment services for substance-related disorders are requested to adhere to these guidelines to the extent possible.

6. Reports. The patient census data report is assigned report control symbol MED 5353-1. This requirement is approved by

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Chief, BUMED for 3 years from the date of this instruction.

A handwritten signature in black ink, appearing to read 'D. C. Arthur', with a stylized, cursive script.

D. C. ARTHUR
Assistant Chief for
Health Care Operations

Available on:
<http://navymedicine.med.navy.mil/insructions/external/external.htm>

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[Categorical Listing] [Numerical Listing]



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

FEB 13 1997

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)

SUBJECT: Policy Memorandum on TRICARE Substance Abuse Treatment

References: (a) 10 U.S.C. Chapter 55
(b) DoD Instruction 1010.6, "Rehabilitation and Referral Services for Alcohol and Drug Abusers," March 13, 1985

This memorandum issues interim policies, procedures, and responsibilities regarding the provision of substance abuse treatment in the Department of Defense under 10 U.S.C. 1090 and other provisions of reference (a) pending revision of reference (b).

1. In support of its mission to provide medical services and support to members of the Armed Forces to keep them physically prepared for deployment, the Department of Defense shall provide a comprehensive TRICARE substance abuse treatment benefit to all members of the armed forces, delivered in a regional environment, with a seamless worldwide continuity of care. In addition, the Department of Defense shall, pursuant to applicable authorities offer substance abuse treatment to all eligible beneficiaries.

2. Service Medical Departments shall assume primary responsibility for the provision of substance abuse treatment within the direct care system and shall work in close coordination with the Lead Agent in each region; the "Lead Agent" is that regional Medical Treatment Facility (MTF) Commander, designated by ASD(HA), who functions as the focal point for regional health services and collaborates with the other MTF commanders within the region to develop an integrated plan for the delivery of health care for their beneficiaries. Lead Agents shall be responsible for establishing region-specific plans and programs in accordance with this policy guidance and for the delivery of substance abuse services in their respective regions. These programs shall reflect a clinical consistency across Services and regions. Regional health care plans shall be designed so as to improve access to substance abuse services for all DoD beneficiaries. Military counseling and treatment facilities, combined with civilian provider networks, shall have attributes of size, composition, mix of providers, and geographical distribution that together will adequately address the substance abuse treatment needs of all DoD beneficiaries.

3. All programs and services shall make the most efficient use of Military Health Services System (MHSS) resources. Primary care managers shall direct patients to an MTF or, when care is not available there, to civilian providers under contract to the Department in a managed care support contract.

4. All programs and services shall achieve a uniform standard of quality and shall meet the accreditation standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or other recognized accrediting organization.

5. All beneficiaries -- active duty members, dependents, and retirees -- are eligible for treatment, following TRICARE guidelines for access. Eligible beneficiaries shall receive substance abuse services as offered through their selected health care option: TRICARE Prime, TRICARE Extra, or TRICARE Standard.

6. All programs and services shall make effective use of information systems. Critical patient data must flow across the MHSS and through all regions; discontinuity of patient information allows for patients to continue to deny their illness and prevents effective and timely interventions, thereby interfering with military readiness. Information and data on patients receiving treatment for substance abuse will be handled no differently than patient data pertaining to any other medical condition. All records and files will be safeguarded in accordance with existing policies and procedures.

7. A continuum of substance abuse care, as determined by ASD (Health Affairs) and which is compatible with the patient placement criteria of the American Society of Addiction Medicine (ASAM), shall be provided. These criteria reflect the philosophy of placing patients in the least intensive/restrictive treatment environment, appropriate to their therapeutic needs. Variable lengths of stay/duration of treatment shall be provided within a variety of treatment settings.

8. Substance abuse services shall be provided by primary care physicians, mental health professionals, certified substance abuse counselors, and other qualified health care providers as determined by appropriate medical authority; e.g. nurse practitioners, social workers, and others with requisite skills and training. In recognition of the unique nature of substance abuse and addictions, providers of care shall be appropriately licensed or certified, and trained in the assessment and treatment of addictive disorders.

9. Adolescents between the ages of 13 and 18 shall be treated separately from adults, in programs staffed by personnel with skills and training in youth and adolescent development.

10. Treatment shall be provided for abusers of both alcohol and illicit drugs, subject to appropriate regulations for active duty members. Nothing in this program creates a right for active duty members to participate in any specific substance abuse program nor limits the ability of commanders to take adverse administrative or punitive action against active duty members.

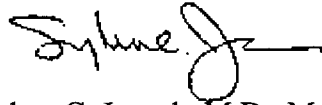
11. Diagnostic criteria for substance abuse and dependence shall be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, (DSM). Abuse and addiction are biopsychosocial conditions, the treatment of which shall be provided by a multi-disciplinary team of providers.

12. Screening, diagnosis, assessment, and treatment outcome evaluation are best accomplished with the use of scientifically-based, well-validated instruments which can be easily used and understood by providers and patients alike. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) have publications which contain descriptions of such instruments. Substance abuse program managers are encouraged to use these sources for guidance on how instruments can best be used. Screening, diagnostic,

assessment, and treatment outcome evaluation instruments are tools which provide limited information and must always be used in conjunction with sound clinical judgment.

13. Substance abuse treatment is a health benefit with clear readiness implications for active duty members.

14. For active duty members, line and command involvement are critical to a comprehensive substance abuse treatment program, particularly in the prevention and early intervention stages, as well as during aftercare and follow-up activities.



Stephen C. Joseph, M.D., M.P.H.

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Last update: 1/5/1999

Treatment Guidelines

1. Scope of Services. Services described in this instruction apply to all active duty and other TRICARE Prime beneficiaries seen within the Navy direct health care system. These services include screening, assessment, and treatment for alcohol and/or other drug abuse problems. The scope and limits of substance abuse treatment services for nonactive duty individuals are governed by the TRICARE benefit. For current information, the local health care benefit agent should be contacted. Programs for adolescents between the ages of 13 and 18 are not covered under this instruction. Adult and adolescent programs shall be separate, with adolescent programs staffed by personnel with skills and training in adolescent development and addiction treatment.

2. Treatment Philosophy. Substance use related problems and disorders are complex and multifaceted. Intervention is intended to motivate and precipitate changes through exposure to a variety of topics and experiences designed to assist individuals in evaluating and learning how to change their relationship with alcohol and other drugs. Engaging individuals in a timely manner and working collaboratively with them to develop individually tailored treatment plans are fundamental precepts for reaching positive treatment outcomes. Methods for improving access to care include the use of open ended counseling groups, regular interface with local commands, proactive case management, etc.

a. Patients will be treated in the least restrictive treatment environment that is appropriate to their therapeutic needs and circumstances. The intensity and setting of intervention will vary in relationship to individual patient needs and responses, and will be consistent with the guidelines of the American Society of Addiction Medicine (ASAM) described in enclosure (3).

b. The length of time in treatment will vary depending on patient needs and responses to treatment. Emphasis is placed on eliminating unnecessary delays in placing patients into an appropriate level of care. Processes that improve access to care include the use of open ended counseling groups, regular interface with local commands, proactive case management, etc.

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c. Treatment for individuals diagnosed with substance dependence is based on clinical indicators that abstinence is necessary for recovery. A primary goal of treatment with this population is to set the foundation for developing an abstinent lifestyle. To this end, the precepts and network of self-help and 12-step programs such as Alcoholics Anonymous are a basic component of the abstinence based treatment program. Spiritual concepts, ideas, and relationships are implied in the six ASAM dimensions, implied in all levels of care, and inherent in the 12-step philosophy.

d. Treatment for individuals diagnosed with an alcohol abuse disorder may have goals and objectives focused on setting responsible limits on the use of alcohol when an abstinent lifestyle is not clinically indicated. Patients for whom this applies are expected to refrain from use of alcohol or other substances while in treatment, until there is an agreed upon strategy for resuming the use of alcohol. Active duty members in jobs or programs requiring abstinence as a condition of active duty status shall be counseled on the adverse consequences of any continued use of alcohol.

e. Use of substances while in treatment, unless part of the treatment plan described above, warrants immediate therapeutic intervention to determine the reasons for the use and possible adjustment of the treatment plan.

3. Evaluations and Treatment Decisions

a. Individuals may refer themselves or be referred for evaluation and treatment services through different avenues. Following reference (e), active duty members who are involved in an alcohol related incident would be referred by their command for evaluation to determine the extent of a substance abuse problem. Individuals referred by another medical service (e.g., emergency services, primary care, mental health, etc.) will usually have an initial screening and/or clinical evaluation, which applies to the precipitating referral. It is the responsibility of the Substance Abuse Treatment Program to ensure these individuals are assessed to determine the existence and extent of substance abuse problems. This evaluation will include a clinical assessment, diagnosis, and recommended level of treatment.

b. Policies and procedures of confidentiality apply to all patients. However, the extent and limits of confidentiality, as it applies to active duty members, shall be addressed before beginning any evaluation. Brief screening tools such as the Michigan Alcoholism Screening Test (MAST), Alcohol Use Disorder Identification Test (AUDIT), and the Alcohol Severity Index (ASI) can aid in determining if further assessment is indicated. Health care providers such as physicians commonly use the following questions to probe for alcohol problems: have you ever tried to Cut down on your drinking? Do you get Annoyed when people talk about your drinking? Do you feel Guilty about your drinking? Have you ever had an Eye-opener (a drink first thing in the morning)? These questions are commonly referred to as CAGE. If a brief screening indicates potential need for treatment, a comprehensive biopsychosocial assessment will be conducted. The information gathered will be of sufficient breadth and depth to develop diagnostic impressions and to recommend initial treatment placement using ASAM patient placement guidelines (see enclosure (4)).

c. Evaluating the presence and potential risk of withdrawal is a fundamental concern in ensuring patient safety. To that end, in addition to the complete history, every attempt will be made to obtain as accurate a picture as possible about the patient's recent alcohol and other substance use, including obtaining information from family and coworkers whenever possible. All counselors and providers involved in the program will be skilled in identifying the signs and symptoms of withdrawal and activation of the local emergency system.

d. Individuals diagnosed with a substance use disorder and referred to treatment (outpatient, intensive outpatient, or residential) shall have a current physical examination (within 30 days) before or upon entry into treatment. The purpose of the evaluation is to assess the medical impact of the substance abuse, prescribe medical regimes as indicated, and medically clear the individual for treatment. Medical assessment should include review for both direct and indirect impact of substance abuse, and should, at a minimum, include a general chemistry panel to include review of electrolytes and liver function.

If not drawn within the past year, human immunodeficiency virus and purefid protein derivative should also be done. A provider may request additional tests based on the patient's history and clinical presentation. It is not required this physical exam be performed by a provider assigned to the Substance Abuse Treatment Program.

e. Patients initially entering the intensive outpatient (IOP) and residential levels are assumed to have a more intense history, and are potentially at higher risk for withdrawal. These patients should be evaluated for withdrawal risk using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA) (see enclosure (5)) or equivalent objective instrument. For residential patients, evaluation should be conducted 4 times per 24-hour period for minimum of 72 hours or as clinically indicated. The structure of IOP programs will shape timing and frequency of withdrawal evaluations. Additionally, screening tests for current use of alcohol and other drugs may be needed to provide the staff with accurate information for treatment. These screening tests include breathalyzers, quantitative enzyme diagnostics, blood alcohol levels, and urine drug/toxicology screens. To ensure patient safety and to monitor progress on treatment goals, it is strongly recommended that alcohol and drug screens be used as indicated on admission (smell of alcohol, symptoms of drug use, or withdrawal), and randomly throughout the course of treatment.

f. Working collaboratively with patients, individualized treatment plans will be developed describing primary problems, goals for treatment, and treatment steps proposed to meet those goals. Problems should be conceptualized within the framework of the ASAM placement criteria using the access and completion crosswalks as guides to ensure appropriate level of intervention (see enclosure (4)). The treatment team will routinely review all treatment plans while the patient is in treatment, documenting the review and all updates and modifications. Treatment plans will be developed for all patients diagnosed with a substance related disorder. Individuals identified as at risk and attending early intervention do not require treatment plans.

g. Reference (c) describes readiness implications of substance abuse which lead to potential employment consequences for active duty members in treatment. For active duty individuals, "treatment noncompliance" may lead to administrative separation from the Navy. Lack of compliance or failure to improve is defined as a patient's inability or unwillingness to achieve the goals and objectives of the individualized treatment plan. A clearly defined list of expectations must be included in the individualized treatment plan signed by the patient and referred to throughout the course of treatment.

(1) Resistance or ambivalence to treatment can be demonstrated in behaviors having moderate to severe negative impact on treatment outcomes. Missed appointments, refusal to sign contracts, and failure to attend self-help groups are examples of minimal participation that typically can be satisfactorily resolved with one-on-one or group therapeutic interventions.

(2) A positive therapeutic milieu can be developed to recognize "slips" or temporary setbacks that can occur at any level of care. Therapeutic discharge, in which treatment is terminated, may be considered as a last resort when a patient's progress is impeded beyond reconciliation. An example of such a situation is a patient's return to abusive drinking despite therapeutic interventions. Case management and utilization review, in combination with clinical judgment, will assist in determining if therapeutic discharge is in the best interest of the patient. In these situations a summary of care will reflect the steps taken to intervene before treatment termination. Active duty members will be returned to their commands. It is the responsibility of the command to determine if the members' discharge from treatment renders them incapable of performing their duties and therefore subject to administrative processing.

4. Program Staff and Organization

a. Shore based substance abuse treatment services may be delivered through free-standing clinics of medical treatment facilities (MTFs), departments within MTFs, as a component of a mental health unit, or as a component of a primary care unit.

The organizational alignment of this program within the MTF will depend on the amount of program resources and structure of the MTF. On board ships, these services will be provided through the medical departments. A licensed health care practitioner, as recognized in reference (g), is responsible for all services provided within this program.

b. Substance abuse treatment programs will deliver services commensurate with staffing and resources. The minimum program will consist of providing screenings and assessments, early intervention services, and continuing care for individuals returning from more intense interventions. Individuals requiring services not available through the MTF will be referred to an appropriate military or civilian facility.

c. The program may be staffed by active duty drug and alcohol counselors, civilian counselors with State certification or licensure, mental health professionals, nurses, and physicians. All providers of care will meet profession specific credentialing and privileging requirements. Individuals in a training status will be supervised by licensed practitioners. Recognizing the unique nature of substance abuse and addictions, providers of care shall be trained in the assessment and treatment of addictive disorders and should attend appropriate professional development conferences and workshops to maintain current knowledge in this field. Funding for continuing education and training is the responsibility of the local command.

(1) Recognizing the biopsychosocial and spiritual nature of addiction treatment, and also the diversity of patient needs, a multidisciplinary approach to treatment is essential. As most programs cannot support a full time multidisciplinary staff dedicated solely to substance abuse, this approach can be accomplished through having multiple professions present at treatment team case reviews and through referral to other programs as needed (e.g., family services, chaplain services, etc.).

5. Records

a. To ensure continuity of care, patients' diagnoses, treatment recommendations, progress notes, and

summaries of care must be entered into the patients' primary or secondary medical record, and, if necessary, a copy entered into the secondary record per reference (h). This classifies the secondary record as either a convenience or temporary record, ensuring that original documentation is entered into the primary record at each visit or upon completion of treatment. Entries in the primary record will note the date when the secondary is opened, the date when it is closed, and the location of the secondary record.

b. Readiness and deployment factors for active duty members require information and regular communication between the treatment program and the member's command regarding treatment progress. A summary of care will be completed whenever an individual meets treatment goals and has completed treatment, and when transferred from one facility to another for continued care. Patients being treated for alcohol dependence may be referred to continuing care or maintenance treatment following an initially more intensive phase of treatment. For these patients, a summary of care including recommended services to enhance recovery will be completed at the time of transfer. The patient and the commanding officer of active duty patients will be provided copies of the summary of care as they are developed.

c. Individuals and their commanding officers will receive documentation of completion for early intervention programs.

d. The command Drug and Alcohol Program Advisor (DAPA) is a source of support to the active duty member as he or she transitions through treatment back into the command. The DAPA may refer to the summary of care for developing a command-monitoring program.

Levels of Care

1. Levels of Care. Treatment programs shall adhere to the principals of a continuum of care model as outlined in *The American Society for Addiction Medicine Patient Placement Criteria (PPC-2)*, reference (e). For convenience of describing different points of the continuum, ASAM has divided the continuum into sectors of five general levels of service. These levels of care are not to be seen as separate and discrete programs, but rather as a way of communicating the intensity of intervention patients need clinically to meet their treatment goals. The transition across different levels of care should be smooth and essentially "transparent" to the patient. Each patient will have a treatment plan outlining the appropriate level of intervention for their needs. The intensity of intervention will fall within the continuum of care, as described below. The designation of a level of service follows the descriptions below:

a. Early Intervention (Level 0.5) is a program intended for individuals whose problems and risk factors appear to be related to substance use but who do not meet the diagnostic criteria for substance related disorders. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use, and to assist the individual in recognizing the harmful consequences of inappropriate substance use. Any member of the staff who has sufficient knowledge and familiarity with addictions to ensure both accurate delivery of information and identification of individuals with problems requiring further intervention can provide these services. Individuals diagnosed with a substance use disorder may attend all or part of the early intervention program as part of their treatment plan for outpatient services. Early intervention programs may be a structured course, with a set length and curriculum. The length of this program should be sufficient to accommodate the individual's ability to comprehend and use the information to avoid further substance use problems.

b. The Outpatient (Level I) program encompasses organized nonresidential services, which may be provided in a wide variety of settings. Addiction treatment personnel provide evaluation and treatment services to individuals diagnosed with substance related disorders. This level is for individuals, diagnosed with a substance use disorder, who are able to meet treatment goals as outpatients with 9 hours of contact or less a week.

Enclosure (3)

Environmental and employment considerations may require that individuals who clinically need this level will receive treatment that is "condensed" or "front-loaded." For example, for many active duty patients, mission requirements will influence whether treatment will occur more often than 9 hours a week for the first 1 to 2 weeks. In such cases, the individual will be considered to be receiving outpatient treatment, as this matches his or her clinical level of functioning. Outpatient services include continuing care or maintenance services. Continuing care is designed to enhance transition into ongoing healthy life-styles. Typically, continuing care or maintenance services follows a more intense period of treatment.

c. The Intensive Outpatient (Level II) program provides a structured day or evening program to individuals diagnosed with substance use disorders whose level of functioning requires more intense intervention than outpatient, but does not require 24 hour supervision. As a general guideline, frequency of contact is usually in blocks of 4 or more hours, 3-5 times per week, up to full day programs. In this level, patients receive essential education and treatment components while being allowed to apply their newly acquired skills within "real world" environments. Programs have the capacity to arrange for medical and psychological consultation, and 24 hour crisis services. As a patient meets individual treatment goals, it is expected, where possible, the individual will move into a less intense intervention, i.e., outpatient services.

d. The Clinically Monitored/Residential (Level III) program is for patients who need a safe and stable living environment to develop sufficient recovery skills. They have been diagnosed with a substance use disorder and have been assessed using patient placement dimensions as requiring a structured, 24 hour program. This program will be staffed 24 hours a day by designated treatment personnel. Medical services need to be readily available, but are not required on site. As a patient progresses through treatment, where possible they will transition to a nonresidential program. Length of stay in a residential program is variable, depending on individual needs and response to treatment, but will generally not exceed 4 weeks.

e. The Medically Managed level of care program is inpatient treatment for individuals requiring medical services for detoxification or other medical complications. When required, this level of service will be coordinated through MTF medical services.

Patient Placement Dimensions and Adult Criteria:
Crosswalk of Levels of Service

1. Patient Placement Dimensions. The patient placement dimensions described in reference (e) provide the common foundation for defining admission, continuing stay, and discharge program criteria, as well as assessing level of functioning and problem areas for the individual. As such, assessment of a patient with these dimensions guides matching the individual with the most appropriate intervention intensity or level of care. The brief questions following each of the six dimensions will assist in assessing the severity of the patient's condition and the intensity of services required.

a. Acute Intoxication and/or Withdrawal Risk. Severe withdrawal risk is possible when there is a past history of withdrawal, the last drink was within 3 days (combined with a history of consistent heavy drinking), or there is a past history of hallucinations, tremulousness, or seizures with alcohol use and withdrawal. If immediate withdrawal risk is severe, the patient should be referred for detoxification evaluation before admission. Consider the following questions:

(1) What risk is associated with the patient's current level of intoxication?

(2) Is there significant risk of severe withdrawal symptoms, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation of chemical use?

(3) Is the patient currently in withdrawal? To measure withdrawal, use the clinical institute withdrawal assessment (CIWA) (enclosure (5)) or other objective instrument.

(4) Does the patient have the supports necessary to assist in ambulatory detoxification, if medically safe?

b. Biomedical Conditions and Complications. Severe biomedical complications are significant medical problems that have not been evaluated or current unstable medical problems such as hypertension, liver problems, chest pain, and diabetes. Members presenting severe biomedical conditions or complications need to be referred for evaluation before entry. Consider the following questions:

(1) Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?

(2) Are there chronic conditions that affect treatment?

c. Emotional and Behavioral Conditions or Complications.

Patients with substance use problems or addiction often present varying degrees of emotional and behavioral difficulties. Negative emotional states, such as anxiety and depression, are frequently situational and are resolved with minimal intervention. However, in other cases the degree of instability associated with these states may present immediate risks or obstacles to treatment and recovery. The more severe the emotional or behavioral problems are, the more intense the level of intervention. If the emotional problems are so severe as to preclude the patient's ability to work on substances abuse issues, referral to other mental health services may be required. It is acceptable to admit patients who are under mental health care or referred by mental health as long as their mental health condition is stable. If a patient presents an imminent danger to self or others, a mandatory mental health referral must be made. Consider the following questions:

(1) Are there current psychiatric illnesses or psychological, behavioral, or emotional problems that need to be addressed or which complicate treatment?

(2) Are there chronic conditions that affect treatment?

(3) Do any emotional or behavioral problems appear to be an expected part of addiction illness or do they appear to be autonomous?

d. Treatment Acceptance and Resistance. The patient's awareness of the problem, their admission of the consequences of the problem, and acceptance of the need for assistance are primary considerations in the treatment process. The level and nature of denial present will suggest the likelihood of continued attempts at controlled use and, therefore, the need for more intense, structured treatment. Also of concern is the distinction between internal versus external motivation, and the patient's willingness to commit to an ongoing treatment process. The more external the motivation and the weaker the willingness to commit, the more structured the intervention will need to be. For patients who are dependent, resistance and denial is to be expected throughout the recovery process. The treatment

placement decision with this dimension should be made on the basis of degree and immediate consequences of the resistance and denial to the treatment process. Consider the following questions:

(1) Does the patient object to treatment?

(2) Does the patient feel coerced into coming to treatment?

(3) Does the patient appear to be complying with treatment only to avoid a negative consequence, or does he or she appear to be self-motivated?

e. Relapse Potential. Many factors contribute to the patient's difficulty in initiating and maintaining abstinence, including physiological, psychological, and environmental concerns. This dimension describes these issues both in terms of immediate ability to abstain as well as the risk of return to active use. The intensity of service will depend on the patient's ability to interrupt impulsive and self-defeating behaviors. Specific concerns in this area include such issues as the level of substance craving, the patient's recognition of internal and external relapse triggers, and history of past attempts to control or abstain. Consider the following questions:

(1) Is the patient in immediate danger of continued use?

(2) Does the patient have any recognition of, understanding of, or skills with which they can cope with their addiction problems to prevent continued use?

(3) What problems will potentially continue to distress the patient if they are not successfully engaged in treatment at this time?

(4) How aware is the patient of relapse triggers, ways to cope with cravings, and skills required to control impulses to continue use?

f. Recovery Environment. The patient's social and interpersonal network, including the atmosphere at their command, may support the recovery process or present major obstacles and relapse stresses. Consideration must be given to the patient's ability to successfully initiate recovery in his or her current environment. Family dysfunction and interaction with drinking or

using peers are to be expected, but assessment must focus on the degree of these stresses and the patient's ability to maintain focus in treatment. In addition, the mobility and mission demands on the active duty population pose unique environmental constraints on providing treatment. This factor must be considered in evaluating the recovery environment. For example, if a patient would qualify on the other dimensions for intensive outpatient services, but the command's operational commitments can not support attendance, the clinically monitored level should be recommended. Consider the following questions:

(1) Are there any family members, significant others, living situations, school, or working situations that pose a threat to treatment success?

(2) Does the patient have supportive friendships, financial resources, educational, or vocational resources that increase the likelihood of treatment success?

(3) Is the patient situated in a remote area, or are other environmental constraints such that less restrictive treatment services are not available?

2. Decisions to prescribe a level of service, and subsequent changes in intensity of intervention as treatment progresses, shall be based on how well the patient is meeting both immediate and long range treatment goals. This is especially important when the interdisciplinary team is considering moving patients into a less structured outpatient level of care. The following tables present crosswalks which match generic assessments on each dimension with intensity of treatment intervention. These crosswalks are intended as a descriptive guide to aid in placing patients in the most appropriate level of care. The first table describes assessments expected upon entering the different levels of intervention. The second table describes assessments expected upon changing levels.

Entry Crosswalk Assessment on Dimension X Treatment Level

DIMENSION	EARLY INTERVENTION		OUTPATIENT SERVICES		INTENSIVE OUTPATIENT SERVICES		RESIDENTIAL
	WITHDRAWAL	No/minimum risk.	No/minimum risk.	Minimum risk; No withdrawal that requires meds; No meds used to mask withdrawal.	Minimal risk; No withdrawal that requires meds; No meds used to mask withdrawal.		
BIOMEDICAL	None to stable, non-interfering.	None to stable, non-interfering.	None to stable, non-interfering.	None to non-interfering. May be under current medical care.	None to non-interfering. May be under current medical care.		
EMOTIONAL/BEHAVIORAL	Able to comprehend and participate in activity. If problems, non-interfering.	Able to comprehend and participate in activity. If problems (anxiety, depression, guilt, etc.), non-interfering.	Able to mild problems, and non-interfering.	None to moderate problems, not able to maintain stability over 72-hour period, i.e., distracted, negative emotions, anxiety, or other conditions requiring monitoring to support treatment goals.			
TREATMENT ACCEPTANCE	Willing to participate.	Amenable to treatment; motivated to pursue treatment goals with support available through outpatient.	Willing to cooperate; able to acknowledge substance related problems. Requires monitoring and motivation strategies, but does not need 24-hour structured care.	Structural milieu required because patient attributes substance problems to others. Despite serious effects of addiction, patient does not relate problems to substance use. High resistance to treatment despite negative consequences.			

Entry Crosswalk Assessment on Dimension X Treatment Level (continued)

DIMENSION	EARLY INTERVENTION	OUTPATIENT SERVICES	INTENSIVE OUTPATIENT SERVICES	RESIDENTIAL
RELAPSE POTENTIAL	Able to achieve program goals in educational setting.	Able to maintain treatment goals with support of outpatient program.	Able to maintain recovery goals with support and motivation provided in an outpatient setting.	High likelihood of substance use without close monitoring as indicated by lack of awareness of triggers, inability to postpone immediate gratification, etc.
RECOVERY ENVIRONMENT OPERATIONAL SCHEDULE	Supportive environment and skills to cope.	Patient can cope effectively with environment to work recovery goals.	Psychosocial environment is supportive enough for patient to work on recovery goals. Work schedule allows stable, consistent attendance, and timely entrance into tx.	Patient lives in environment in which tx unlikely to succeed, i.e., chaotic family, high level conflict, other members with active substance abuse. Patient performs job where continued substance use represents substantial imminent risk to self or others. Work schedule does not allow support timely, consistent tx. Distance between command and tx precludes participation in lower level of care.

Exit Cross Walk Assessment on Dimension X Treatment Level

DIMENSION	EARLY INTERVENTION		OUTPATIENT SERVICES		INTENSIVE OUTPATIENT SERVICES		RESIDENTIAL
	WITHDRAWAL	WITHDRAWAL risk requiring tx in another setting. Problems arise requiring tx in another setting.	WITHDRAWAL risk requiring treatment in another setting. Problems arise requiring treatment in another setting.	WITHDRAWAL risk requiring treatment in another setting. Problems arise requiring treatment in another setting.	WITHDRAWAL risk requiring treatment in another setting. Problems arise requiring treatment in another setting.	WITHDRAWAL risk requiring treatment in another setting. Problems arise requiring treatment in another setting.	
BIOMEDICAL		Problems arise requiring tx in another setting.	Problems arise requiring treatment in another setting.	Problems arise requiring treatment in another setting.	Problems arise requiring treatment in another setting.	Problems arise requiring treatment in another setting.	Problems arise requiring treatment in another setting.
EMOTIONAL/ BEHAVIORAL		Problems stable, non-interfering. Problems arise requiring tx in another setting.	Problems stable, non-interfering. Problems arise requiring tx in another setting.	Problems stable, non-interfering. Problems interfering with treatment, requiring treatment in another setting.	Problems stable, non-interfering. Problems interfering with treatment, requiring treatment in another setting.	Problems no longer require 24-hour monitoring, stabilized and non-interfering with recovery plan. Problems identified are not responding to treatment and require another setting.	
TREATMENT ACCEPTANCE		Satisfies program goals. Fails to attend, participate, or complete assignments.	Patient recognizes extent of substance problem. Patient understands consequences of continuing pattern. Patient applying essential knowledge and skill necessary to sustain treatment goals. Patient consistently failed treatment objectives to degree that further progress unlikely.	Patient recognizes severity of problem and understands self-defeating relationship with substance; patient applying essential skills necessary to sustain sobriety through self help/continuing care. Patient consistently failed treatment objectives to degree that transfer to another setting indicated.	Patient able to adhere to self-directed recovery plan; patient recognizes severity of problem and understands self-defeating relationship with substance; patient applying essential skills necessary to sustain sobriety through self help/continuing care. Patient consistently failed to achieve tx objectives to degree that further progress unlikely.	24-hour structure no longer needed; patient recognizes severity of problem; patient accepts and commits to specific plan for less intensive treatment. Patient consistently failed to achieve tx objectives to degree that further progress unlikely.	

Exit Crosswalk Assessment on Dimension X Treatment Level (continued)

DIMENSION	EARLY INTERVENTION	OUTPATIENT SERVICES	INTENSIVE OUTPATIENT SERVICES	RESIDENTIAL
RELAPSE POTENTIAL	Satisfies program goals, develops alternative coping skills to prevent further alcohol related incidents.	Patient applying essential knowledge and skills to control/abstain from substance use. Increased craving, seeking behaviors require increased intensity treatment.	Patient has integrated, internalized skills for addressing craving and relapse issues. Patient having increased craving/using behaviors necessitating increased intensity treatment.	Patient capable of following and comprehending specific plan for continuing abstinence; risk of relapse outside of residential structure is low. Patient not committed to continued care, reached max benefits, non-amenable to treatment.
RECOVERY ENVIRONMENT/ OPERATIONAL SCHEDULE	Satisfies program goals, develops alternative sources of support.	Sufficient support for recovery to allow transfer to less intensive care. Patient unable to cope with recovery environment without more intensive treatment.	Patient has adequate social system support to use self directed treatment with low risk of relapse; patient functioning adequately in work, social, and primary relationships. Non-supportive or deteriorating social system or work schedule interferes, necessitating increased intensity treatment.	Problems in social/interpersonal environment responds to tx, allows transfer to lower intensity treatment. Patient developed coping skills needed to address current environmental obstacles.

Clinical Institute Withdrawal Assessment of Alcohol Scale

Patient _____ Date _____ Time _____

Pulse or heart rate taken for 1 minute _____

Blood pressure _____/_____

Nausea and Vomiting Center

Ask: "Do you feel sick to your stomach? Have you vomited?"

Observation:

- 0 no nausea and no vomiting
- 1 mild nausea with no vomiting
- 2
- 3
- 4 intermittent nausea with dry heaves
- 5
- 6
- 7 constant nausea, frequent dry heaves, and vomiting

Tremor Center

Arms extended and fingers spread apart.

Observation:

- 0 no tremor
- 1 not visible but can be felt fingertip to fingertip
- 2
- 3
- 4 moderate, with patient's arms extended
- 5
- 6
- 7 severe, even with arms not extended

Proximal Sweats Center

Observation:

- 0 no sweat visible
- 1 barely perceptible sweating, palms moist
- 2
- 3
- 4 beads of sweat obvious on forehead
- 5
- 6
- 7 drenching sweats

Anxiety Center

Ask: "Do you feel nervous?"

Observation:

- 0 no anxiety, at ease
 - 1 mildly anxious
 - 2
 - 3
 - 4 moderately anxious or guarded, so anxiety is inferred
 - 5
 - 6
 - 7 equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions
-

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Agitation Center

- Observation:
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview,
or constantly thrashes about

Tactile Disturbances Center

Ask, "Have you had any itching, pins-and-needles sensations, burning, numbness, or do you feel bugs crawling on or under your skin?"

- Observation:
0 none
1 very mild itching, pins and needles, burning, or numbness
2 mild itching, pins and needles, burning, or numbness
3 moderate itching, pins and needles, burning, or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Auditory Disturbances Center

Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?"

- Observation:
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Visual Disturbances Center

Ask, "Does the light appear to be too bright? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?"

- Observation:
0 not present
1 very mild
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations
-

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Headache, Fullness in Head Center

Ask: "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity.

- Observation
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

Orientation and Clouding of Sensorium Center

Ask: "What day is this? Where are you? Who am I?"

- Observation:
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Total score _____

Rater's initials _____

Maximum possible score 67

A scoring greater than 25 indicates severe withdrawal (impending DTs). If score is less than 10 after two 8-hour reviews, monitoring can stop. If scores are above 20, the patient should be assessed hourly until the symptoms are under control.

Definitions

The definitions used in this instruction correspond to references and enclosures of this instruction, and are intended for the clinical and administrative management of the substance abuse treatment program.

Assessment. Assessment is an ongoing process of gathering information about patients' strengths, weaknesses, problems, and needs. This information is evaluated and integrated into treatment recommendations and plans. A diagnosis is based on data gathered in an initial assessment.

At Risk. Describes an individual that has had some difficulties related to substance use, but who does not meet the diagnostic criteria of substance use disorder. Usually individuals identified as being "at risk" will be referred to a focused, early intervention, educationally based program such as IMPACT.

Biopsychosocial Interview. Substance abuse effects all aspects of an individual's life. Therefore, a comprehensive interview includes investigation of such areas as biology (physical consequences associated with use of alcohol and other drugs, other physical illnesses, etc.), emotions, attitudes, behavior (psychology), and relationships (sociology).

Case Management. Case management is the clinical and administrative support and coordination of therapeutic services that make up the treatment plan and facilitate a positive outcome.

Continuum of Care. A full range of services encompassing initial assessment, early intervention, variety of outpatient services, 24-hour clinical management, and 24-hour medical management. It assumes that patients move smoothly within the continuum, with intensity of intervention, varying as the needs change.

Drug and Alcohol Program Advisor (DAPA). Collateral duty defined within OPNAVINST 5350.4 series, is responsible to commanding officer. Acts as liaison between command and treatment program for referral and command treatment support issues.

IMPACT. A structured, educationally based early intervention counseling program aimed at increasing the personal awareness of at risk individuals.

Intake. The administrative and assessment procedures upon entering a treatment program. It typically follows an initial diagnostic assessment that has recommended a treatment intervention.

Lapse and Relapse. Lapse and relapse are not unusual when treating addicted individuals. Every effort should be made to formulate a strategy for intervening with a patient who is experiencing difficulty in making progress in treatment or maintaining a recovery program. Discharge from treatment is a last resort when all other avenues for reconciliation have been exhausted.

Least Restrictive Environment. Treating in the least restrictive environment is the principle that individuals are treated in the most appropriate and therapeutic setting that is no more restrictive than required to assist them in meeting the goals of the treatment plan.

Levels of Care or Service. Services ranging from early intervention through outpatient services to medically managed intensive inpatient care. The intensity or level of intervention individuals receive is guided by admission, continued stay and discharge criteria. These criteria are based on a thorough assessment using the patient placement criteria.

Multidisciplinary Team. Staff characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of a patient's care. The intent of a multidisciplinary team is to be able to address all aspects of an individual's life that has been impacted by substance abuse.

Orientation. Presenting to the patient the general nature and goals of the program; mutual expectations; program rules governing conduct; and patient rights.

Screening. The process by which an individual is determined appropriate and eligible for admission to a particular program. Screening may include the use of short, commonly used questions or surveys such as the CAGE or AUDIT to assist in determining if the individual has a substance related disorder.

Setting. Clinical environment such as hospital, doctor's office, clinic, counseling center, classroom, etc., that meets accreditation standards for delivery of services.

Substance Related Disorders. For the purpose of this document, substance related disorders refers to an ailment related to the taking of a drug of abuse (including alcohol) that meets the diagnostic criteria for substance use disorder as outlined in the Diagnostic and Statistical Manual. Impairment or disability can manifest in the areas of either mental or physical functioning, or both.

Summary of Care. Identifies patient diagnosis, treatment, summary of care progress notes and any comments regarding continuing care. For active duty members, summaries are completed and provided to the patient and his or her command at the end of treatment and whenever the member is transferred from one treatment facility to another.

Treatment Plan. The treatment plan is the identification and prioritization of problems needing resolution. Working together, the patient and the counselor establish immediate and long-term goals; and decide on the treatment methods and resources to be used. The goals of treatment will be consistent with the dimensions of the patient placement criteria, allowing the use of the generic admission, continued stay, and discharge criteria as a guide for best level of treatment intervention. Treatment plans will be reviewed and updated regularly.